CMS Region 7 Updates

08/22/2016

ACA/Marketplace Updates

Consumer Action Needed - Initial Warning Notices Sent to Consumers Who May Be Enrolled in Marketplace Coverage with APTC/CSRs and Medicaid or CHIP (also called Medicaid/CHIP Periodic Data Matching)

Key Takeaway: Consumers determined eligible for minimum essential coverage (MEC)[1] Medicaid or CHIP are not eligible for a Marketplace plan with advance payments of the premium tax credit (APTC) and/or income-based cost-sharing reductions (CSRs). This summer, Medicaid/CHIP Periodic Data Matching (PDM) functionality will be different from past Medicaid/CHIP PDM processes. This time, the Marketplace will end APTC/CSRs for dually-enrolled consumers who do not take action in response to the Medicaid/CHIP PDM initial warning notice.*

Earlier this month, the Marketplace sent an initial warning notice to these consumers, requesting that they take action by a specific date. Consumers who do not take action in time will be sent a final notice, informing them that: (a) the Marketplace will end any APTC/CSRs being paid on their behalf, (b) that their Marketplace coverage will continue without financial help, and (c) that APTC/CSR eligibility for anyone else on the Marketplace application will be redetermined, if applicable. Consumers will also be sent an updated Eligibility Determination Notice (EDN). All notices will be mailed to the household contact, and will be available in consumers' Marketplace accounts. If affected consumers contact assisters with questions, assisters can help them understand the notice(s) and complete the necessary next steps.

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[1] Most Medicaid or CHIP is considered MEC. Some forms of Medicaid cover limited benefits (like Medicaid that only covers emergency care, family planning or pregnancy-related services) and aren't considered MEC. (For more information on which Medicaid programs are considered MEC, visit: HealthCare.gov/medicaid-limited-benefits/).

Overview

Consumers who are determined eligible for or are enrolled in MEC Medicaid or CHIP are ineligible for APTC and CSRs to help pay for the cost of their Federally-Facilitated Marketplace (Marketplace)[1] plan premium and covered services.[2], [3] Medicaid/CHIP PDM is the process the Marketplace uses to identify consumers who are enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP (i.e. "dually-enrolled" consumers). This month, following the most recent data match with state Medicaid and CHIP agencies, the Marketplace sent an **initial warning notice** to the household contact for dually-enrolled[4] consumers, stating that if they do not take action by the date in the notice, the Marketplace will end any APTC/CSRs being paid on their behalf, and their Marketplace coverage will continue without financial help.[5] The notice tells consumers (and provides instructions) to do one of the following by a specified date: end their Marketplace coverage with APTC/CSRs if they are enrolled in Medicaid or CHIP; OR update their Marketplace application to tell the Marketplace that they're not enrolled in Medicaid/CHIP. The notice was mailed and/or posted to consumer Marketplace accounts, depending on what the consumer selected as his or her communication preference.

In Fall 2016, at least 30 days following the initial notice, a **final notice** will be sent to consumers who did not respond to the initial warning notice by the specified date, letting them know that they are still enrolled in a Marketplace plan but will no longer receive financial help for their coverage. For anyone else on the application who is still enrolled in a Marketplace plan, their coverage will continue and eligibility for APTC/CSRs, if applicable, will be redetermined. ***Dually-enrolled consumers who do not want to pay full cost for their share of the Marketplace plan premium and covered services should end their Marketplace coverage immediately.*** The final notice includes instructions for next steps, such as ending Marketplace coverage, confirming whether or not someone is enrolled in Medicaid/CHIP, and appealing the Marketplace's decision; it also includes the date that the changes to financial assistance become effective. The Marketplace will also send an updated EDN. All notices will be mailed and/or posted to consumer Marketplace accounts.

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[1] References to the "Marketplace" throughout refer to the Federally-Facilitated Marketplace and State-Based Marketplaces using the federal eligibility and enrollment platform.

[2] Generally, a consumer who is eligible for income-based CSRs will also be eligible for APTC. However, not all consumers who are eligible for APTC will be eligible for income-based CSRs.

[3] In accordance with recent guidance from the Internal Revenue Service (IRS), consumers determined ineligible for Medicaid or CHIP and eligible for APTC when the consumer enrolls in a Marketplace plan may claim the premium tax credit, even if the consumer was enrolled in both Medicaid or CHIP that qualifies as MEC and a qualified health plan through the Marketplace. For more information, visit: https://www.irs.gov/PUP/taxpros/best-_practices_resolving_1095_conflicts.pdf.

[4] Due to technical limitations, dually-enrolled consumers in the following Marketplace states did not receive notices in this round of Medicaid/CHIP PDM: GA, NH, NJ, and WY. Consumers in these states will not be affected by this round of Medicaid/CHIP PDM.

[5] If a consumer still wants a Marketplace plan after having been determined eligible for MEC Medicaid or CHIP, he or she will have to pay full price for his or her share of the Marketplace plan premium and covered services, without APTC or income-based CSRs, if otherwise eligible.

Q&A: How to help consumers who receive the notice(s)

Q1: When and how are these notices being sent to consumers?

A1: The Marketplace sent initial warning notices in August 2016 to the household contact for applications with one or more dually-enrolled consumers. In Fall 2016, the Marketplace will send a final notice to the household contact for applications with consumers who did not take action by the date in the initial warning notice. The Marketplace will also send an updated EDN for all consumers in the household. All notices are mailed and/or posted to consumer Marketplace accounts.

Q2: How will consumers identify the Medicaid/CHIP PDM notices, and what do the notices say?

A2: The subject of the initial warning notice reads *"Warning: People in your household may lose financial help for their Marketplace coverage."* The notice lists the dually-enrolled consumers, and provides instructions to either end their Marketplace coverage with APTC/CSRs, or update their Marketplace application to tell the Marketplace that they're not enrolled in Medicaid or CHIP. The notice also provides instructions for consumers who want more information about Medicaid or CHIP, who aren't sure if their Medicaid or CHIP coverage qualifies as MEC, or who aren't sure whether they're enrolled in or have been determined eligible for Medicaid or CHIP.

The subject of the final notice reads *"IMPORTANT: People in your household are still enrolled in a Marketplace plan but will no longer receive financial help for their coverage."* The notice lists the dually-enrolled consumers who did

not take action by the date in the initial warning notice, tells them the date that Marketplace coverage without financial assistance becomes effective, and alerts the impacted consumers that they should end Marketplace coverage immediately if they don't want to pay full cost for their share of the Marketplace plan premium and covered services. The notice also provides instructions for consumers who want more information about Medicaid or CHIP, who aren't sure if their Medicaid or CHIP coverage qualifies as MEC, OR who aren't sure whether they're enrolled in or eligible for Medicaid or CHIP, as well as information on how to submit an appeal to the Marketplace if a consumer believes his or her financial assistance was ended incorrectly.

Copies of both notices are available in English and Spanish.

Q3: As an assister, why might consumers contact me, and how can I help them?

A3: Consumers who receive either/both of the Medicaid/CHIP PDM notices may contact assisters: (a) for help understanding the notice(s); (b) for help ending Marketplace coverage with APTC/CSRs; (c) for help updating their Marketplace application to tell the Marketplace they're not enrolled in Medicaid/CHIP; (d) if they don't think they're enrolled in Medicaid or CHIP; (e) if they aren't sure if they've been determined eligible for, (f) if they aren't sure if they're enrolled in Medicaid or CHIP; or (g) if they want more information about whether their Medicaid or CHIP coverage qualifies as MEC. Here are some examples of the ways that assisters can help consumers who contact them:

- **Help consumers understand the notice(s)**. Explain that the notice has been sent to them because the Marketplace has identified them as being enrolled in Marketplace coverage with APTC/CSRs and Medicaid or CHIP. This is important because consumers who've been determined eligible for Medicaid or CHIP are not eligible for a Marketplace plan with APTC/CSRs. Consumers who receive the notices should take immediate action.

- **Encourage consumers who have been determined eligible for or are enrolled in Medicaid or CHIP to take immediate action** to end their Marketplace coverage with APTC/CSRs. Explain the financial impact of not ending Marketplace coverage.

o See these instructions on HealthCare.gov to help a consumer end Marketplace coverage when he or she gets Medicaid or CHIP.

- https://www.healthcare.gov/medicaid-chip/cancelling-marketplace-plan/

o Medicaid/CHIP PDM User Interface User Guide

- www.healthcare.gov/downloads/marketplace-medicaid-chip-guide.pdf

- **Help consumers who aren't enrolled in Medicaid or CHIP to update their Marketplace application accordingly.**

o Medicaid/CHIP PDM User Interface User Guide

- www.healthcare.gov/downloads/marketplace-medicaid-chip-guide.pdf

- **Inform consumers who don't think they're enrolled in Medicaid or CHIP, who aren't sure if their Medicaid or CHIP benefits qualify as MEC, or if they aren't sure if they've been determined eligible for or if they're enrolled in Medicaid or CHIP,** that they should contact their state Medicaid or CHIP agency to confirm their enrollment status (instructions for doing so are in the notices). If the state agency confirms that the consumer is not eligible for or enrolled in MEC Medicaid or CHIP coverage, he or she should update his or her Marketplace application to tell the Marketplace that he or she is not enrolled in Medicaid or CHIP. However, if the state agency confirms that the consumer is eligible for or enrolled in MEC Medicaid or CHIP coverage, the consumer should end his or her Marketplace coverage with APTC/CSRs immediately (refer to the Medicaid/CHIP PDM User Interface User Guide, above, for more information).

- **Advise consumers who want more information about Medicaid or CHIP** to contact their state Medicaid or CHIP agency.

Q4: What if a consumer is enrolled in MEC Medicaid or CHIP but believes he or she is actually eligible to remain enrolled in Marketplace coverage with APTC/CSRs?

A4: A consumer who's enrolled in MEC Medicaid/CHIP may believe he or she is eligible to remain enrolled in Marketplace coverage with APTC/CSRs if he or she experienced a change in family size or household income that may make him or her ineligible for Medicaid/CHIP. The consumer should contact his or her state Medicaid/CHIP agency to inform them of the change. If the Medicaid or CHIP agency informs the consumer that he or she is not eligible for Medicaid or CHIP, the consumer should return to the Marketplace and update his or her application to tell the Marketplace that he or she is not enrolled in Medicaid or CHIP; the consumer can remain in his or her Marketplace coverage with APTC/CSRs, if otherwise eligible. If the state agency confirms that the consumer is eligible for MEC Medicaid or CHIP, the consumer should end his or her Marketplace coverage with APTC/CSRs immediately. (Refer to the Medicaid/CHIP PDM User Interface User Guide, above, for more information).

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Marketplace Seeks Enrollment Testimonials

The Marketplace is looking for people who are currently covered through a plan on HealthCare.gov and willing to share their story to encourage others to get covered. Interested consumers could appear in television, radio, print and/or digital ads and on social media. We are primarily looking for people ages 18 to 34 but would like to talk to anyone who wants to share their story.

We are interested in learning more about:

- How insurance changed their lives;
- How they have used their coverage; and
- How financial help made their premiums affordable.

We are looking for both English and Spanish speakers. Please share with your partners and forward the contact information for anyone interested to Laura Salerno at laura.salerno@cms.hhs.gov.

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What's New with Find Local Help?

Find Local Help has released a new functionality to allow Assisters to add locations via the upkeep tool at https://localhelp.healthcare.gov/update-organization-information/#/. Now, Assisters may submit a Find Local Help request to add locations online. With this change, the Find Local Help spreadsheets are no longer necessary. For more information on adding new locations via the upkeep tool, please refer to the FLH Quick Reference Guide at https://marketplace.cms.gov/technical-assistance-resources/local-help-reference-guide.pdf

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NEW Assister Resources: Links / Rural & Urban Trends / Living with HIV

Healthcare.gov and Marketplace.cms.gov updates

- Medicaid/CHIP Periodic Data Matching (Medicaid/CHIP PDM) – August 2016 (slides)
- Health coverage for American Indians & Alaska Natives
- Direct link to Tribal Leaders Directory with new, interactive tribal map
- Turning 26? What You Need to Know About the Marketplace (Fact Sheet)

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Recorded Webinar Presentation "Geographic Variation in Health Insurance Marketplaces: Rural and Urban Trends in Enrollment, Firm Participation, Premiums, and Cost Sharing in 2016"

On Tuesday August 9th, Timothy McBride, PhD, Professor, Health Policy and Management at Washington University in Saint Louis, along with Abigail Barker, PhD at the RUPRI Center for Rural Health Policy Analysis provided an overview of Health Insurance Marketplace performance in rural areas along several dimensions. During the webinar they described trends in enrollment, firm participation, premiums, deductibles, and out-of-pocket maximum values. They also provided context to the ongoing discussion on the importance of competition in driving positive outcomes for consumers and for the government.

A recording of this webinar is available on the Rural Health Research Gateway website (https://www.ruralhealthresearch.org/).

For more information, read more about the Health Insurance Marketplaces: Premium Trends in Rural Areas policy brief.

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CMS Announces Next Phase In Largest-Ever Initiative To Improve Primary Care In America

The Centers for Medicare & Medicaid Services (CMS) opened the application period for practices to participate in the new nation-wide primary care model, Comprehensive Primary Care Plus (CPC+). CPC+ is a five-year primary care medical home model beginning January 2017 that will enable primary care practices to care for their patients the way they think will deliver the best outcomes and to pay them for achieving results and improving care. CPC+ is an opportunity for practices of diverse sizes, structures, and ownership who are interested in qualifying for the incentive payment for Advanced Alternative Payment Models through the proposed Quality Payment Program. CMS estimates that up to 5,000 primary care practices serving an estimated 3.5 million beneficiaries could participate in the model.

CPC+ is a public-private partnership in 14 regions across the nation. CPC+ is a multi-payer model - Medicare, state Medicaid agencies, and private insurance companies partner together to support primary care practices - so CMS selected the regions based on payer interest and coverage. By aligning Medicare, Medicaid, and private insurance, CPC+ moves the health care system away from one-size-fits-all, fee-for-service to a model that supports clinicians delivering the care that best meets the needs of their patients and improves health outcomes.

The following regions were selected for CPC+. Eligible practices in these 14 regions may apply between August 1 and September 15, 2016 to participate in CPC+:

1. Arkansas: Statewide

2. Colorado: Statewide
3. Hawaii: Statewide
4. Kansas and Missouri: Greater Kansas City Region
5. Michigan: Statewide
6. Montana: Statewide
7. New Jersey: Statewide
8. New York: North Hudson-Capital Region
9. Ohio: Statewide and Northern Kentucky Region
10. Oklahoma: Statewide
11. Oregon: Statewide
12. Pennsylvania: Greater Philadelphia Region
13. Rhode Island: Statewide
14. Tennessee: Statewide

"As a key part of CPC+, CMS and partner payers are committed to supporting primary care practices of all sizes, including small, independent, and rural practices," said Dr. Patrick Conway, CMS deputy administrator and chief medical officer. "We see CPC+ as the future of primary care in the U.S. and are pleased to partner with payers across the country that are aligned in this mission to transform our health care system. This model allows primary care practices to focus on what they care about most – serving their patients' needs when and how they choose."

Building on the Comprehensive Primary Care initiative that launched in late 2012, CPC+ will benefit patients by helping primary care practices:

- Support patients with serious or chronic diseases achieve their health goals
- Give patients 24-hour access to care and health information
- Deliver preventive care
- Engage patients and their families in their own care
- Work together with hospitals and other clinicians, including specialists, to provide better-coordinated care

Practices may participate in one of two CPC+ tracks. In Track 1, CMS will pay practices a monthly fee in addition to regular Medicare fee-for-service payments. In Track 2, practices will receive the monthly fee, as well as a hybrid of reduced Medicare fee-for-service payments and up-front comprehensive primary care payments to allow greater flexibility in how practices deliver care. Practices in Track 2 will provide more comprehensive services for patients with complex medical and behavioral health needs, including, as appropriate, a systematic assessment of their psychosocial needs and an inventory of resources and supports to meet those needs. To promote high quality and high value care, practices in both tracks will also receive prospective performance-based incentive payments that they will either keep or have to pay back to CMS based on their performance on quality and utilization metrics. In addition, practices that participate in CPC+ may qualify for the additional incentive payments available for the Advanced Alternative Payment Models in the proposed Quality Payment Program beginning 2019.

The Affordable Care Act, through the creation of the Center for Medicare and Medicaid Innovation, allows for the testing of innovative payment and service delivery models, such as the CPC+ model, to move our health care system toward one that rewards clinicians based on the quality, not quantity of care they provide patients. Today's announcement is part of the Administration's broader strategy to improve the health care system by paying providers for what works, unlocking health care data, and finding new ways to coordinate and integrate care to improve quality. This new model supports the Administration's goal to have 50 percent of traditional Medicare payments flowing through alternative payment models by 2018 (already, 30 percent of Medicare payments go through alternative models).

For questions about the model or the application process, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus or email CPCplus@cms.hhs.gov

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Summer/Fall 2016 Medicaid/CHIP Periodic Data Matching Notices

CMS is reaching out to a small number of consumers identified as enrolled in both Marketplace coverage with financial assistance *and* Medicaid or the Children's Health Insurance Program (CHIP). Initial warning notices will be sent to these consumers requesting that they take steps to end their Marketplace coverage with financial assistance or update their Marketplace application to tell the Marketplace that they are not eligible for Medicaid or CHIP. This notice alerts consumers that if they do not take action by the date indicated, their financial help for their Marketplace plan will end and they will have to pay full cost for their share of the Marketplace plan premium and covered services. Consumers who do not take action by the date in the initial warning notice will receive a final notice and an updated eligibility determination notice.

Helpful Weblinks:

1. Medicaid/CHIP External FAQs: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/PDM-Round-3-External-FAQ-for-States-final-clean-8-1-16.pdf
2. Medicaid/CHIP Periodic Data Matching Warning Notice: https://marketplace.cms.gov/applications-and-forms/pdm-initial-warning.pdf (English) https://marketplace.cms.gov/applications-and-forms/pdm-initial-warning-spanish.PDF (Spanish)
3. Medicaid/CHIP Periodic Data Matching Final Notice: https://marketplace.cms.gov/applications-and-forms/pdm-ending-financial-help.pdf (English) https://marketplace.cms.gov/applications-and-forms/pdm-ending-financial-help-spanish.pdf (Spanish)

CACQuestions@cms.hhs.gov. For assistance with Navigator program questions, submit inquiries to your CMS project officer.

For additional information regarding assister training, please use the following resources:

- Launch of Plan Year 2017 FFM Assister Training – updated July 5, 2016 (slides)
- Quick Reference Guide: Plan Year 2017 FFM Registration and Training Steps for Assisters – updated July 5, 2016
- Quick Reference Guide: Plan Year 2017 Computer Configuration Requirements – updated July 5, 2016
- 2016 Assister Recertification Bulletin: Guidance Regarding Training, Certification, and Recertification for Navigators and Certified Application Counselors in the Federally-facilitated Marketplaces

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Special Enrollment Period Reference Chart

The chart is a tool for those who are helping people enroll in health coverage through a special enrollment period, and focuses on the circumstances that trigger a SEP, who can trigger a SEP, and the effective date of coverage once a health plan is selected.

Updates to the chart include:

- **Changes to the eligibility criteria for the SEP triggered by a permanent move.**
- **New organization of SEPs according to six broad categories of situations that can trigger a SEP in the Health Insurance Marketplace.**
- **Addition of a column indicating how to generally access a SEP. (Please note that this column is limited to the Federally-Facilitated Marketplace.)**
- **Removal of a column indicating who can use a SEP because once a SEP is triggered, it is available to all family members, regardless of who experienced the triggering event.**

Special Enrollment Period Reference Chart

Download chart (PDF)

View chart

In addition, our team within the Center on Budget and Policy Priorities (CBPP) published a new guide to school-based outreach that shares strategies groups identify as key to the success of their work in schools and describes lessons learned to help avoid approaches that have yielded disappointing results.

CBPP Guide to School-Based Outreach for Health Coverage Enrollment

Download PDF (29pp)

Read the report

To access additional resources or view video recordings of *Health Reform: Beyond the Basics* webinars, please visit Health Reform: Beyond the Basics.

As we approach the next open enrollment period, we will continue to develop new resources and tools. If you have any questions, please don't hesitate to contact us!

Health Reform: Beyond the Basics is a project of the Center on Budget and Policy Priorities designed to provide training and resources that explain health coverage available through

Medicaid, CHIP, and the Marketplace, and is intended for those working on the implementation of health reform. For more information on Beyond the Basics, please visit www.healthreformbeyondthebasics.org.

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Language Access Tagline Frequently Asked Questions

Today, The Centers for Medicare & Medicaid Services (CMS) released FAQs that address the two frequently asked questions received from issuers and agents/brokers regarding CMS' language access guidance.

For more information see attached or click here: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Tagline-FAQs-7-27-16-clean-letterhead-MM-508.pdf

###

Affordable Care Act payment model continues to improve care, lower costs

The Independence at Home Demonstration continues to provide high quality primary care services for chronically ill Medicare beneficiaries in the home setting while saving the Medicare program money, according to a new analysis released today by the Centers for Medicare & Medicaid Services (CMS).

"The Independence at Home Demonstration is a patient-centered model that supports providers in caring for chronically ill patients in their own homes," said Dr. Patrick Conway, CMS acting deputy administrator and chief medical officer. "These results continue to support what most patients already want – the ability to have high quality care in the home setting".

The CMS analysis found that, for the second performance year, Independence at Home participants saved Medicare more than $10 million – an average of $1,010 per beneficiary – while delivering higher quality patient care in the home. CMS will award incentive payments of $5.7 million to seven participating practices that succeeded in reducing spending while improving quality.

In the second performance year, 15 practices served more than 10,000 Medicare beneficiaries. According to the CMS analysis, all 15 practices improved quality from the first performance year in at least two of the six quality measures for the Demonstration. Four practices met the performance measures for all six quality measures.

These quality results mean improved care for Medicare beneficiaries who are participating in Independence at Home practices. On average, beneficiaries:

- Have follow-up contact from their provider within 48 hours of a hospital admission, hospital discharge, or emergency room visit;
- Have fewer hospital readmissions within 30 days;
- Have their medication identified by their provider within 48 hours of discharge from the hospital;
- Have their preferences documented by their provider;
- Use inpatient hospital and emergency room services less for conditions such as diabetes, high blood pressure, asthma, pneumonia, or urinary tract infection.

The Independence at Home Demonstration is part of the Administration's broader strategy to improve the health care system by paying practitioners for what works, unlocking health care data, and finding new ways to coordinate and integrate care to improve quality. In March 2016, the Administration announced it reached its goal, nearly one year ahead of schedule, of tying 30 percent of Medicare payments to alternative payment models that reward the quality of care over the quantity of services provided to beneficiaries.

For more information on the Independence at Home Demonstration performance year two results, including individual practice results, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-09.html.

To learn more about the Independence at Home Demonstration, please visit: https://innovation.cms.gov/initiatives/Independence-at-Home/.

###

Medicare and Medicaid Updates

Medicare Advantage Value-Based Insurance Design Model

Overview

The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation is announcing refinements to the design of the second year of the Medicare Advantage Value-Based Insurance Design (MA-VBID) model. The MA-VBID model is an opportunity for Medicare Advantage plans (MA plans), including Medicare Advantage plans offering Part D benefits (MA-PD plans), to offer clinically nuanced benefit packages aimed at improving quality of care while also reducing costs.

In the second year of the model, beginning January 1, 2018, CMS will: open the model test to new applicants; conduct the model test in three new states - Alabama, Michigan, and Texas; add rheumatoid arthritis and dementia to the clinical categories for which participants may offer benefits; make adjustments to existing clinical categories; and change the minimum enrollment size for some MA and MA-PD plan participants.

Value-Based Insurance Design (VBID) generally refers to health insurers' efforts to structure enrollee cost sharing and other health plan design elements to encourage enrollees to use high-value clinical services – those that have the greatest potential to positively impact enrollee health. VBID approaches are increasingly used in the commercial market, and evidence suggests that the inclusion of clinically-nuanced VBID elements in health insurance benefit design may be an effective tool to improve the quality of care while reducing its cost for Medicare Advantage enrollees with chronic diseases. As part of the "better care, smarter spending, healthier people" approach to improving health care delivery, CMS will test VBID in Medicare Advantage and measure whether structuring patient cost sharing and other health plan design elements encourages enrollees to use health care services in a way that improved their health and reduces costs.

The first year of the MA-VBID model will begin January 1, 2017 and run for five years. CMS will announce the MA plans participating in the test's first year in September 2016. CMS expects to release a Request for Applications for the second year of the model test in the fall of 2016, and will accept proposals from MA and MA-PD plans to offer VBID benefits in 2018.

In its first year, CMS will test the model in seven states: Arizona, Indiana, Iowa, Massachusetts, Oregon, Pennsylvania, and Tennessee. Beginning January 1, 2018, CMS will also test the model in Alabama, Michigan, and

Texas. These states have been selected in order to be generally representative of the national Medicare Advantage market, including urban and rural areas, areas with both high and low average Medicare expenditures, areas with high and low prevalence of Low-Income Subsidies, and areas with varying levels of penetration of and competition within Medicare Advantage. Test states have also been selected based on the availability of appropriate paired comparison areas for the purposes of evaluation. Eligible MA plans in these states, upon CMS approval, may offer varied plan benefit designs for enrollees who fall into certain clinical categories identified and defined by CMS. Benefit design changes made through this model may reduce cost sharing and/or offer additional services to targeted enrollees; however, targeted enrollees can never receive fewer benefits or be charged higher cost sharing than other MA enrollees in their plan as a result of the model.

Background

The existing Medicare Advantage "uniformity" requirement generally requires that an MA plan's benefits and cost sharing be the same for all plan enrollees. Because of this, clinically-nuanced VBID approaches have generally not been incorporated into MA or MA-PD plans.

The model will test the hypothesis that giving MA plans flexibility to offer supplemental benefits or reduced cost sharing to targeted groups of enrollees with CMS-specified chronic conditions in order to encourage the use of services that are of highest value to them, will lead to higher-quality and more cost-efficient care. The increase in high-quality, cost-efficient care is expected to improve beneficiary health, reduce utilization of avoidable high-cost care, and reduce costs for plans, beneficiaries, and the Medicare program. The model is also intended to improve outcomes and reduce costs by encouraging targeted enrollees to obtain care from high-value providers and by providing new supplemental benefits specifically tailored to targeted enrollees' clinical needs.

The MA-VBID model is authorized under Section 1115A of the Social Security Act (added by section 3021 of the Affordable Care Act) (42 U.S.C. § 1315a), which authorizes the Center for Medicare and Medicaid Innovation to test innovative health care payment and service delivery models that have the potential to reduce Medicare, Medicaid, and Children's Health Insurance Program expenditures while preserving or enhancing the quality of beneficiaries' care. CMS will test this model in the Medicare program through a limited waiver of the Medicare Advantage and Part D uniformity requirements.

Description

The MA-VBID model supports improved health outcomes and health care cost savings or cost neutrality through the use of structured patient cost sharing and other health plan design elements that encourage enrollees to use high-value clinical services. The MA-VBID model will provide flexibility for MA and MA-PD plans accepted into the model to develop clinically-nuanced benefit designs for enrollee populations that fall within certain clinical categories.

The conditions are:

- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Patient with Past Stroke
- Hypertension
- Coronary Artery Disease
- Mood disorders
- Rheumatoid Arthritis (starting in 2018)
- Dementia (starting in 2018)

In addition to developing interventions targeted at all enrollees in one or more of the above categories, participating MA plans will have the flexibility to identify specific combinations of the listed chronic conditions for one or more "multiple co-morbidities" groups and establish tailored VBID interventions for each group. Participating MA plans are required to provide VBID benefits to all VBID-eligible enrollees in the selected group. Participating MA plans selecting the Mood Disorders group will also have additional flexibility to focus on specific conditions within that group.

For each of the selected enrollee groups, participating plans may select one or more plan design modifications from a menu of four general approaches. Within each approach, plans have flexibility on how (and to what extent) to implement that approach. Plans may vary their proposed interventions from one target population to another, and from one participating plan to another. CMS will also consider proposals for related variants of these interventions offered to targeted groups of enrollees, such as supplemental benefits conditional on participation in a disease management program.

The four approaches are:

1. Reduced Cost Sharing for High-Value Services

Plans can choose to reduce or eliminate cost sharing for items or services, including covered Part D drugs, that they have identified as high-value for a given target population. Participating plans have flexibility to choose which items or services are eligible for cost-sharing reductions; however, these services must be clearly identified and defined in advance, and cost-sharing reductions must be available to all enrollees within the target population.

Examples of interventions within this category include eliminating co-pays for eye exams for diabetics and eliminating co-pays for angiotensin converting enzymeinhibitors for enrollees who have previously experienced an acute myocardial infarction.

2. Reduced Cost Sharing for High-Value Providers

Plans can choose to reduce or eliminate cost sharing when providers that the plan has identified as high-value treat targeted enrollees. Plans may identify high-value providers based on their quality and not solely based on cost, across all Medicare provider types, including physicians/practices, hospitals, skilled-nursing facilities, home health agencies, ambulatory surgical centers, etc.

Examples of interventions within this category include reducing cost sharing for diabetics who see a physician who has historically achieved strong results in controlling patients' HbA1c levels and eliminating cost sharing for heart disease patients who elect to receive non-emergency surgeries at high-performing cardiac centers.

3. Reduced Cost Sharing for Enrollees Participating in Disease Management or Related Programs

Participating plans can reduce cost sharing for an item or service, including covered Part D drugs, for enrollees who choose to participate in a plan-sponsored disease management or similar program. This could include an enhanced disease management program, offered by the plan as a supplemental benefit, or it could refer to specific activities that are offered or recommended as part of a plan's basic care coordination activities. Plans using this approach can condition enrollee eligibility for cost-sharing reductions on meeting certain participation milestones. For instance, a plan may require that enrollees meet with a case manager at regular intervals in order to qualify. However, plans cannot make cost-sharing reductions conditional on achieving any specific clinical goals (e.g., a plan cannot condition cost-sharing reductions on enrollees achieving certain thresholds in HbA1c levels or body-mass index).

Examples of interventions within this category include elimination of primary care co-pays for diabetes patients who meet regularly with a case manager and reduction of drug co-pays for patients with heart disease who regularly monitor and report their blood pressure.

4. Coverage of Additional Supplemental Benefits

Under this approach, participating plans can make coverage for supplemental benefits available only to targeted populations. Such benefits may include any service currently permitted under existing Medicare Advantage rules for supplemental benefits.

Examples of interventions within this category include physician consultations via real-time interactive audio and video technologies for diabetics, or supplemental tobacco cessation assistance for enrollees with COPD.

Eligible Applicants

The MA-VBID model test is open to all qualifying MA and MA-PD plans in the test states that submit acceptable programmatic proposals to CMS. Only certain MA and MA-PD plan types are eligible and certain restrictions apply to multi-state plans.

CMS will generally restrict the model test to plans with a minimum enrollment in the test states of 2,000 enrollees. However, beginning in 2018, a MA organization participating in the model test with at least one plan with enrollment over 2,000 enrollees may have additional Plan Benefit Packages (PBPs) participate with a minimum enrollee requirement of 500 enrollees; an additional plan benefit package using this lower enrollment requirement may be from that MA organization or other organizations with the same parent organization. CMS may also grant an exception upon request.
Additionally, Plans must meet minimum quality thresholds, including: being rated by CMS at three stars or higher, not consistently low-performing, not an outlier in the CMS past performance analysis, not under sanction, and able to pass a program integrity screening.

The plan must have been offered in at least three annual coordinated election (open enrollment) periods prior to the open enrollment period for the year for which the plan is applying to participate. There is no cap on the total number of participating plans.

More information and Application Process

More information about the MA-VBID model test can be found in the model's announcements and other documents, available at http://innovation.cms.gov/initiatives/VBID. The announcement includes instructions for providing CMS with feedback on this model test's design. Please also save the date for a webinar on the MA-VBID model test, to be held on August 25, 2016. Registration information is available on the same site.

CMS will accept applications for the second year of the MA-VBID model via a Request for Applications (RFA), to be released shortly. Once released, application materials will be available at:
http://innovation.cms.gov/initiatives/VBID.

For more information on the Center for Medicare and Medicaid Innovation's division of Health Plan Innovation, please visit: http://innovation.cms.gov/initatives/HPI.

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CMS Updates Nursing Home Five-Star Quality Ratings

New quality measures are now included in the overall calculation for Nursing Home star ratings

The Centers for Medicare & Medicaid Services (CMS) updated the popular Nursing Home Compare Five-Star Quality Ratings to incorporate new measures, giving families more information at their fingertips to help them make important decisions about care. These new measures look at successful discharges, emergency visits, and re-hospitalizations, and complement other nursing home measures previously announced in April.

"When residents and their families are faced with important decisions about care, they need an easy, transparent way to figure out which facility is the best fit for them or their loved ones," said CMS Deputy Administrator and Chief Medical Officer Patrick Conway, M.D., MSc. "With this update, star ratings will provide an even more accurate reflection of the services that nursing homes provide."

CMS is committed to making sure that residents, their family members, and caregivers have the most meaningful information possible when they consider facilities. Nursing Home Compare is the agency's public information website that provides information on how well Medicare and Medicaid certified nursing homes provide care to their residents.

Nursing homes receive four different star ratings on the Nursing Home Compare website (each ranging from 1 to 5 stars): one for each of the components – health inspections, staffing, and quality measures – and one for an overall rating, which is calculated by combining each of the three component star ratings. With the new quality measures added to the calculations, the quality measures star rating for each nursing home, as well as the overall rating, will likely change.

As part of a broader effort at data transparency and consumer choice, CMS hosts a number of sites to help those seeking health care compare various facilities based on star ratings. They include: Hospital Compare, Physician Compare, Medicare Plan Finder, Dialysis Compare, and Home Health Compare. These star rating programs are part of the Administration's Open Data Initiative which aims to make government data freely available and useful while ensuring privacy, confidentiality, and security.

For more information on today's announcement, please visit here:
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-10.html

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MLN Connects

News & Announcements

- Hospital IPPS and LTCH PPS Final Rule Policy and Payment Changes for FY 2017
- SNFs: Final FY 2017 Payment and Policy Changes
- Hospice Benefit: Final FY 2017 Payment and Policy Changes
- IRFs: Final FY 2017 Payment and Policy Changes
- Inpatient Psychiatric Facilities: Final FY 2017 Payment and Policy Changes
- CMS Announces Next Phase in Largest-ever Initiative to Improve Primary Care in America
- CMS Extends, Expands Fraud-Fighting Enrollment Moratoria Efforts in Six States
- First Release of the Overall Hospital Quality Star Rating on Hospital Compare
- Home Health Agencies: New PEPPER Available
- Partial Hospitalization Programs: New PEPPER Available
- Physician Compare: 2014 Quality Data Available
- Teaching Hospital Closures: Apply for Resident Slots by October 31, 2016
- PQRS: EIDM Accounts Required to Access Feedback Reports and 2015 Annual QRURs
- Replacement of Accessories for Beneficiary-Owned CPAP Device or RAD
- Administrative Simplification Statutes and Regulations
- ICD-10 Coding Resources

- Vaccines are Not Just for Kids
- Medicare Announces Participants in Effort to Improve Access, Quality of Care in Rural Areas
- Affordable Care Act Payment Model Continues to Improve Care, Lower Costs
- ESRD QIP PY 2020 Proposed Rule: New Fact Sheet and Video
- CMS to Release a CBR on Positive Airway Pressure Devices, Respiratory Assist Devices and Accessories in August
- TEP on IMPACT Act Quality Measures: Nominations due August 21

Provider Compliance

- Hospital Discharge Day Management Services
- Preventive Services

Claims, Pricers & Codes

- ICD-10 GEMS for 2017 Available

Upcoming Events

- PQRS Feedback Reports and Informal Review Process for Program Year 2015 Results Call — August 10
- Data Collection on Resources Used in Furnishing Global Services Information Session — August 11
- IMPACT Act: Data Elements and Measure Development Call — August 31
- National Partnership to Improve Dementia Care and QAPI Call — September 15
- ESRD QIP PY 2020 Proposed Rule Call-In Session — August 16
- Global Surgery Proposed Data Collection Town Hall — August 25
- IMPACT Act: Data Elements and Measure Development Call — August 31
- National Partnership to Improve Dementia Care and QAPI Call — September 15

Medicare Learning Network® Publications & Multimedia

- Remittance Advice Information: An Overview Fact Sheet — Reminder
- Medicare Costs at a Glance: 2016 Educational Tool — Revised
- Timely Reporting of Provider Enrollment Information Changes MLN Matters® Article — New
- IRFs: Improving Documentation Positively Impacts CERT Web-Based Training Course — New
- Physician Compare Call: Addendum — New
- RHCs HCPCS Reporting Requirement and Billing Updates MLN Matters Article — Revised
- MLN Guided Pathways Provider Specific Medicare Resources Booklet — Revised
- PECOS Technical Assistance Contact Information Fact Sheet — Revised

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CMS examines inappropriate steering of people eligible for Medicare or Medicaid into Marketplace plans

Concerns raised about impact of 3rd party premium provider & affiliated organization payments

The Centers for Medicare & Medicaid Services (CMS) today issued a request for information seeking public comment on concerns that some health care providers and provider-affiliated organizations may be steering people eligible for, or receiving, Medicare and/or Medicaid benefits into Affordable Care Act-compliant individual market

plans, including Health Insurance Marketplace plans, for the purpose of obtaining higher reimbursement rates. CMS also sent letters to all Medicare-enrolled dialysis facilities and centers informing them of this announcement.

The request for information and letters to providers focus on situations where patients may be steered away from Medicare or Medicaid benefits, which can among other concerns, result in beneficiaries experiencing a disruption in the continuity and coordination of their care as a result of changes to their network of providers. These actions reflect ongoing efforts by the CMS Center for Program Integrity to address possible issues in the Marketplace that could affect the integrity of the programs for both consumers and issuers, and the costs of the individual insurance market, while at the same time help ensure patients are enrolled in the right plan for them.

"Ensuring access to high quality patient care is a top priority for us. We are concerned about reports that some organizations may be engaging in enrollment activities that put their profit margins ahead of their patients' needs," said CMS Acting Administrator Andy Slavitt. "These actions can limit benefits for those who need them, potentially result in greater costs to patients, and ultimately increase the cost of Marketplace coverage for everyone."

"It is improper to influence people away from Medicare or Medicaid coverage for the purpose of financial gain," said Shantanu Agrawal, M.D., CMS Deputy Administrator and Director of the Center for Program Integrity. "Our goal is to protect patients from being unduly influenced in their decisions about their health insurance options, and to protect the integrity of all the programs we oversee."

Currently, third-party payment of premiums and cost sharing of qualified health plans in the individual market by health care providers such as physicians, medical facilities or affiliated non-profit organizations are discouraged, but the ultimate decision about accepting those payments are left to health insurance companies. This guidance does not apply to certain federal, state or local government programs, Ryan White HIV/AIDS programs or Indian tribes, tribal organizations and urban Indian organizations, which are expressly permitted to pay insurance premiums for consumers under CMS regulations. Recently, concerns have been raised that certain providers or organizations affiliated with specific providers may steer consumers into individual market plans, including Marketplace health plans, because they would receive higher payment rates under a private plan than under Medicare or Medicaid.

In addition to asking for more information on instances of problematic steering of consumers to individual market plans, CMS is also considering potential regulatory and operational options to prohibit or limit premium payments and routine waiver of cost-sharing for qualified health plans by health care providers, revisions to Medicare and Medicaid provider enrollment rules, the imposition of civil monetary penalties for individuals that fail to provide correct information about consumers enrolling in a plan, and potential changes that would allow issuers to limit their payment to health care providers to Medicare-based amounts for particular services and items of care. In particular, CMS is looking at authorities to impose civil monetary penalties on health care providers when their actions result in late enrollment penalties for Medicare eligible individuals who are steered to an individual market plan and, as a result, are delayed in enrolling in Medicare.

Like reducing inappropriate use of special enrollment periods and other efforts, today's steps are a part of the Administration's ongoing work to strengthen and expand the Health Insurance Marketplace.

The request for information can be found on the Federal Register website at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-20034.pdf

The letter to all dialysis providers can be found on the CMS website at: https://www.cms.gov/about-cms/components/cpi/downloads/rfi-medicare-dialysis.pdf

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Upcoming Webinars and Events

2016 Health Insurance Marketplace Training Calendar for CMS Partners

https://marketplace.cms.gov/technical-assistance-resources/training-materials/2016-marketplace-training-calendar.pdf

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Learn to improve identification and management of HCV in your rural practice.

Join Drs. Paul Kwo and Rajender Reddy in the Webinar, New HCV Testing Policies: Reality for Rural Clinics, as they discuss current HCV testing guidelines, the practicalities of testing in already-busy rural clinics, and the initial steps for evaluating liver health in patients with newly identified HCV.

This webinar is part of a series of educational offerings centered around the needs of the rural healthcare provider. The learning components of the series, which concludes with a master competency examination and certificate recognition, will arm primary care professionals with knowledge and competence specific to rural practice settings and will improve the capacity for high-quality HCV care across the country.

New HCV Testing Policies: Reality for Rural Clinics
Date: Thursday, August 25
Time: 2:00 - 3:00 PM Central Time
Cost: Free
Target Audience: Primary care clinicians who care for patients outside of metropolitan areas

Presenters
Paul Kwo, MD and **Rajender Reddy, MD**

REGISTER TODAY

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"Assister Forum: Preparing for 2017 Open Enrollment and Beyond

Please join the Center for Consumer Information and Insurance Oversight (CCIIO Marketplace CEO Kevin Counihan, along with Consumer Support Group Director Jennifer Beeson and other CMS/CCIIOO leadership for a forum on Monday, September 26, 2016 via remote live streaming.

This forum will promote best practices and share strategies for enhancing assister capacity to perform outreach, education and enrollment activities for the 2017 Open Enrollment period for the individual market (OE 4) and beyond.

Registration is now open.

Topics: Navigator Metric Reporting, Plan Compare 2.0, Consumer Engagement and Outreach Strategies for OE 4.

Who: All Assisters are invited to live stream the Forum

When: Monday, September 26, 2016 from 8:30am – 4:00pm (CT)

RSVP: Registration is **required** for remote live streaming and will remain open until Thursday, September 22, 2016 at 11:00 am CT. To view the agenda and register for remote live streaming, please visit

https://www.eventbrite.com/e/assister-forum-preparing-for-2017-open-enrollment-beyond-live-stream-registration-27154487804

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